
Shared Agenda for the Virginia Chronic Disease Prevention Collaborative Network

September 2012



INTRODUCTION

Chronic diseases such as heart disease, cancer, stroke, and diabetes are the most common, costly and preventable health problems that shorten and reduce the quality of life of Virginians across the lifespan. The Milken Institute projects that in 2013 the cost for treating these conditions combined with the impact of lost workdays and lower employee productivity will cost Virginia \$56 billion. Adopting a healthy lifestyle by avoiding tobacco products, being physically active, eating well and receiving preventive services (e.g., age-appropriate screenings, vaccinations) can greatly reduce an individual's risk of developing these chronic diseases and save thousands of dollars in medical costs.

To reduce the burden of chronic disease in Virginia there is a statewide movement to create partnerships and, in unison, work collaboratively to improve the health status and quality of life of Virginians. By working together, limited resources can be leveraged and maximized and initiatives can be better coordinated and integrated to have a greater impact on health outcomes. To successfully transform this vision into reality, a chronic disease collaborative network, which includes a diverse and inclusive set of internal and external stakeholders, was established and a shared agenda was created. By actively engaging all collaborative network members in the planning and decision-making process, the *Virginia Chronic Disease Prevention Shared Agenda* serves as an action plan for strategizing, planning initiatives, allocating resources and identifying future opportunities.

The *Chronic Disease Prevention Shared Agenda* was created by the Virginia Department of Health and its key stakeholders as a blueprint for tackling the existing and escalating chronic disease issues in Virginia. The primary purpose of the agenda is to rally partners around shared priorities and strategies that will improve the health and quality of life of all Virginians. To monitor progress within each of the priority areas, key performance measures will be established and baseline data for Virginia and the U.S. will be gathered, compared and tracked over time to document changes in health outcomes (See Appendix A: Measures for Key Indicators).

PARTNERS

AARP Virginia	Virginia Academy of Family Physicians
AgriAbility	Virginia Asthma Coalition
Alliance for the Prevention and Treatment of Nicotine Addiction	Virginia Asian Chamber of Commerce
American Cancer Society – Central Virginia	Virginia Beach Health District
American Diabetes Association	Virginia Breast Cancer Foundation
American Heart Association	Virginia Community Health Care Association
American Lung Association	Virginia Commonwealth University
Anthem/Wellpoint	Virginia Dental Association
Arthritis Foundation – Mid Atlantic Region	Virginia Department of Aging and Rehabilitative Services
Augusta Medical Center	Virginia Department of Behavioral Health and Developmental Services
Baptist General Convention	Virginia Department of Conservation and Recreation
Bike Virginia	Virginia Department of Education
Blue Ridge Medical Center	Virginia Department of Fire Programs
Boat People, SOS, Inc.	Virginia Department of Health
Bon Secours	Virginia Department of Medical Assistance Services
Cancer Action Coalition of Virginia	Virginia Department of Social Services
COPD Foundation	Virginia Department of Transportation
Central Virginia Health District	Virginia Diabetes Council
Chesapeake Health District	Virginia Foundation for Healthy Youth
Community Care Network of Virginia	Virginia Healthcare Foundation
Commonwealth Council on Aging	Virginia Health Quality Center
Crater Health District	Virginia Hispanic Chamber of Commerce
Cross Over Ministry	Virginia Hospital and Healthcare Association
Department of Human Resources Management	Virginia Interfaith Center
ECDC African Community Center	Virginia Medical Reserve Corps
EPA – Office of Research and Development	Virginia Navigator
Medical Society of Virginia	Virginia Network of Geospatial Health Research
Medical Society of Virginia Foundation	Virginia Public Health Association
Partnership for People with Disabilities	Virginia Rural Health Association
Peninsula Health District	Virginia State Police
Piedmont Health District	Virginia Technical Institute
Prevention Connections	Walgreens
Richmond Academy of Medicine	Western Tidewater Free Clinic
Richmond City Health District	Women’s Health Virginia
Riverside Health System	YMCA
Senior Navigator	
Urban League of Greater Richmond	
University of Virginia	

BACKGROUND

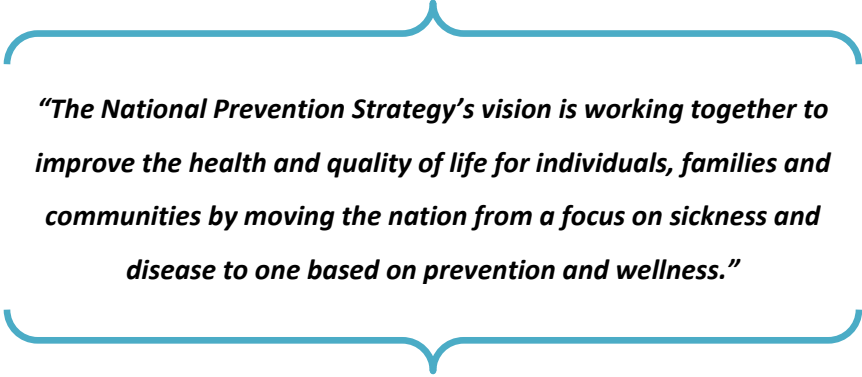
Preventing disease is critical to helping Americans live healthier and longer lives. Poor diet, physical inactivity, tobacco and alcohol use is directly tied to chronic disease and escalating health care costs. In addition, there are many predictors of health associated with the communities we live in such as housing, education, workplaces, transportation, and environment that present special challenges to public health. A healthy and fit America is essential to the country's current and future productivity, economic health and national defense.

To improve American's health, prevention needs to be an integral part of everyone's life. We need to work together to champion and create healthy and safe communities, expand and strengthen clinical and community-based preventive services, empower individuals to get involved in their health and eliminate health disparities that unfairly lead to poor health outcomes and quality of life for so many Americans. An investment in prevention will have broad implications and positively affect all Americans; families and communities will enjoy the benefits of healthy environments, people will lead healthier and more productive lives, businesses will thrive through individual productivity and innovation and health care costs will be contained.

To achieve a healthy and fit nation, the National Prevention, Health Promotion, and Public Health Council comprised of 17 departments, agencies and offices across the federal government released the Nation Prevention and Health Promotion Strategy in June 2011. The National Prevention Strategy was intended to transition our current health system focused on sickness and disease to health and wellness by improving the health of individuals, families and communities through prevention.

The National Prevention Strategy emphasizes a collaborative, cross-sector approach by encouraging partnerships among federal and state agencies, business and industry, health systems, community organizations and individual Americans. It encourages organizations from all sectors to promote prevention-oriented policies (e.g., safe and affordable housing and physical activity opportunities, access to healthy foods and preventive health services, clean air and water, etc.) that create healthy neighborhoods and communities. It is believed that once these fundamental needs are met, people will be more empowered to exercise, eat healthy foods and seek the recommended and age-appropriate preventive health services to maintain a healthy and productive life.

The National Prevention Strategy is the first integrated approach that identifies priorities to improve the health of Americans and offers evidence-based recommendations and strategies to accomplish this vision. It essentially lays the foundation for lifelong wellness that can create and sustain a healthy and thriving America.



“The National Prevention Strategy’s vision is working together to improve the health and quality of life for individuals, families and communities by moving the nation from a focus on sickness and disease to one based on prevention and wellness.”

As the Nation’s guide to health and wellness, the National Prevention Strategy identifies four strategic directions and seven targeted priorities. The four strategic directions include:

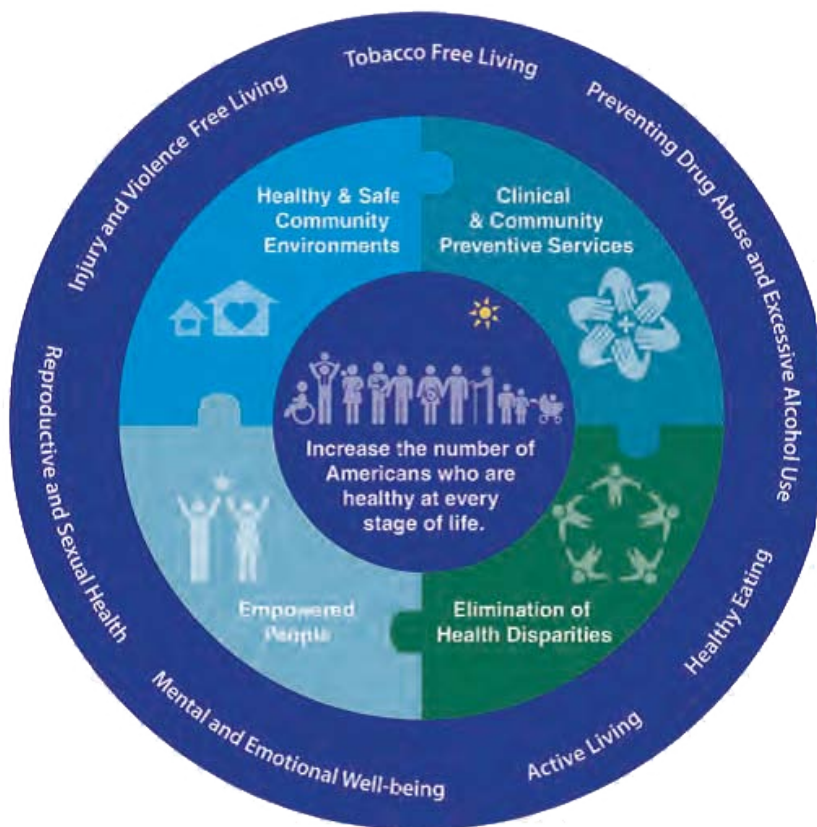
- (1) Creating healthy and safe community environments,
- (2) Ensuring that critical preventive health services are available and affordable to all Americans,
- (3) Empowering people to make the healthy choice, and
- (4) Eliminating health disparities.

The seven targeted priorities include:

- Tobacco Free Living
 - Preventing Drug Abuse and Excessive Alcohol Use
 - Healthy Eating
 - Active Living
 - Injury and Violence free Living
 - Reproductive and Sexual Health
 - Mental and Emotional Well-Being
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Within this conceptual framework, each priority area lists evidence-based recommendations and strategies that are intended to reduce the burden of the leading causes of disease or illness (e.g., heart disease, cancer, stroke, etc.).

“The National Prevention Strategy’s overarching goal is to increase the number of Americans who are healthy at every stage of life.”



VIRGINIA'S SHARED AGENDA FOR CHRONIC DISEASE PREVENTION

Virginia's *Shared Agenda for Chronic Disease Prevention* was based on the principles and core values put forth by the National Prevention Council in the form of the National Prevention Strategy. The National Prevention Strategy is broad in scope and addresses many aspects of an individual's social, economic and built environment that potentially have a significant influence on health. Although the Collaborative Network recognizes that all of these factors play an important role in an individual's health and well-being, the Virginia agenda was deliberately focused on a subset of National Prevention Strategy priorities to increase attention and concentration on specific activities that align with existing and new chronic disease efforts. As such, action strategies related to substance abuse, reproductive and sexual health, injury free living, and mental and emotional well-being were excluded at this time.

To create the agenda, a diverse group of stakeholders was assembled on May 24, 2012, and later formed the Virginia Chronic Disease Prevention Collaborative Network. Network members represent state agencies, community organizations, non-profit groups and foundations, faith-based organizations, health systems, health insurers, state coalitions and more. To begin the process, Collaborative Network members were surveyed and asked to rank the National Prevention Strategy's four strategic directions and seven targeted priorities in order of importance. Based on the survey results, the Virginia Department of Health selected three key priority areas (i.e., active living, healthy eating, and tobacco free living) and added a fourth area labeled clinical preventive services. National Prevention Strategy recommendations and action strategies were then listed for each of the selected priority areas and shared with the Collaborative Network for ranking and prioritization. In the end, similar action strategies were consolidated for clarity and organizational purposes.

The final product is an agenda that key stakeholders and partners can embrace and use to guide their future interventions and actions to create healthier individuals, families and communities in Virginia. In addition, the agenda serves as an excellent tool to integrate chronic disease prevention activities across the collaborative to avoid duplication, share limited resources and maximize health outcomes. To monitor progress, interventions and activities implemented by members across the collaborative network will be collected and analyzed semi-annually to measure progress as well as identify gaps and areas of opportunity.

ACTIVE LIVING

Recommendation 1: Facilitate access to safe, accessible, and affordable places for physical activity.

1. Make physical activity facilities available to the local community.
2. Develop and institute policies and joint use agreements that address liability concerns and encourage shared use of physical activity facilities (e.g., school gymnasiums, community recreation centers).
3. Offer opportunities for physical activity across the lifespan (e.g., aerobic and muscle strengthening exercise classes for seniors, adaptive fitness and sports options for children and adults with physical disabilities).

Recommendation 2: Promote and strengthen school and early learning policies and programs that increase physical activity.

1. Support walking and biking to schools programs (e.g., “Safe Routes to School”) and work with local governments to make decisions about selecting school sites that can promote physical activity.
2. Support schools and early learning centers in meeting physical activity guidelines and providing daily education and recess that focuses on maximizing physically active time.
3. Offer low or no-cost physical activity programs (e.g., intramural sports, physical activity clubs).

Recommendation 3: Encourage community design and development that supports physical activity.

1. Convene partners (e.g., urban planners, architects, engineers, developers, transportation, law enforcement, public health) to consider health impacts when making transportation or land use decisions.
2. Sponsor a new or existing park, playground, or trail, recreation or scholastic program, or beautification or maintenance project.
3. Design safe neighborhoods and communities that encourage active transportation and physical activity (e.g., include sidewalks, bike lanes, adequate lighting, multi-use trails, walkways, and parks).

Recommendation 4: Support workplace policies and programs that increase physical activities.

1. Adopt policies and programs that promote walking, bicycling, and use of public transportation (e.g., provide access to fitness equipment and facilities, bicycle racks, walking paths, and changing facilities with showers).
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Recommendation 5: Assess physical activity levels and provide education, counseling, and referrals.

1. Support clinicians in conducting physical activity assessments, providing counseling, and referring patients to allied health care and health and fitness professionals (e.g., provide training to clinicians, implement clinical reminder systems).
2. Encourage schools to participate in fitness testing (e.g., the President's Challenge) and support individualized self-improvement plans.

HEALTHY EATING

Recommendation 1: Help people recognize and make healthy food and beverage choices.

1. Provide nutrition information to customers (e.g., on menus), make healthy options and appropriate portion sizes the default, and limit marketing of unhealthy food to children and youth.
2. Screen for obesity by measuring body mass index and deliver appropriate care according to clinical practice guidelines for obesity.
3. Assess dietary patterns (both quality and quantity of food consumed), provide nutrition education and counseling, and refer people to community resources (e.g., Women, Infants, and Children's Supplemental Nutrition Program {WIC}; Head Start; County Extension Services; and nutrition programs for older Americans).

Recommendation 2: Increase access to healthy and affordable foods in communities.

1. Increase the availability of healthy food (e.g., through procurement policies, healthy meeting policies, farm-to-work programs, farmers markets).
2. Lead or convene city, county, and regional food policy councils to assess local community needs and expand programs (e.g., community gardens, farmers markets) that bring healthy foods, especially locally grown fruits and vegetables, to schools, businesses, and communities.

Recommendation 3: Implement organizational and programmatic nutrition standards and policies.

1. Ensure that foods served or sold in government facilities and government-funded programs and institutions (e.g., schools, prisons, juvenile correctional facilities) meet nutrition standards consistent with the Dietary Guidelines for Americans.

Recommendation 4: Improve nutritional quality of the food supply.

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1. Eliminate high-calorie, low-nutrition drinks from school and worksite vending machines and cafeterias, and provide greater access to water.
 2. Work with hospitals, early learning centers, health care providers, community-based organizations and worksites to implement breastfeeding policies and programs (e.g., adopt lactation policies that provide space and break time for breastfeeding employees and offer lactation management services and support such as breastfeeding peer support programs).
 3. Use maternity care practices that empower new mothers to breastfeed such as the Baby-Friendly Hospital standards.
 4. Implement culturally and linguistically appropriate social supports for breastfeeding such as marketing campaigns and breastfeeding peer support programs.

CLINICAL and COMMUNITY PREVENTIVE SERVICES

Recommendation 1: Support the implementation of community-based preventive services and enhance linkages with clinical care.

1. Provide easy-to-use employee information about evidence-based clinical preventive services and how to access free or low-cost resources (e.g., free clinics, Federally Qualified Health Centers) that provide these types of services.
2. Expand public-private partnerships to implement community preventive services and connect patients to community resources (e.g., school-based oral health programs, community-based diabetes prevention programs, tobacco quitlines).
3. Promote and support use of worksites, health systems, retail sites, schools, churches, and community centers for the provision of evidence-based preventive services and comprehensive programs.

Recommendation 2: Reduce barriers to accessing clinical and community preventive services, especially among populations at greatest risk.

1. Foster collaboration among community-based organizations, the education and faith-based sectors, businesses, and clinicians to identify underserved groups and implement programs to improve access to preventive services.
 2. Expand the use of community health workers, patient navigators, home visiting programs, patient support groups and health coaches.
 3. Establish patient reminders (e.g., mailing cards, sending e-mails, or making phone calls when a patient is due for a preventive health service) and clinical reminder systems (e.g., electronic health records with reminders or cues, chart stickers, vital signs stamps, medical record flow sheets) to encourage patients to follow-up on preventive services.
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4. Expand hours of operation, provide child care, offer services in convenient locations (e.g., near workplaces) or use community or retail sites to provide preventive services.
 5. Communicate with patients in an appropriate manner so that patients can understand and act on their advice and directions.
 6. Inform people about the range of preventive services they should receive and the benefits of preventive services to increase usage.

Recommendation 3: Support the National Quality's Strategy on Improving Cardiovascular Health.

1. Increase delivery of clinical preventive services (e.g., ABCS) by Medicaid and Children's Health Insurance Program (CHIP) providers.
2. Inform patients about the benefits of preventive services and offer recommended clinical preventive services, including the ABCS, as a routine part of care.

Recommendation 4: Use payment and reimbursement mechanisms to encourage delivery of clinical preventive services.

1. If the Affordable Care Act is withheld, reduce or eliminate out-of-pocket costs for certain preventive services, and educate and encourage individuals to access these services.

Recommendation 5: Enhance coordination and integration of clinical, behavioral and complementary health strategies.

1. Adopt medical home or team-based patient care models.
2. Facilitate coordination among diverse care providers (e.g., clinical care, behavioral health, community health workers, complementary and alternative medicine).

Recommendation 6: Expand the use of interoperable health information technology.

1. Create interoperable systems to exchange clinical, public health and community data, streamline eligibility requirements, and expedite enrollment processes to facilitate access to clinical preventive services and other social services.
 2. Train providers (e.g., doctors, nurses, dentists, allied health professionals) to use health information technology and offer patients recommended clinical preventive services as a routine part of their health care.
 3. Adopt and use certified electronic health records and personal health records.
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TOBACCO FREE LIVING

Recommendation 1: Support comprehensive tobacco free and other evidence-based tobacco control policies.

1. Implement and sustain comprehensive tobacco prevention and control programs, including comprehensive tobacco free and smoke free policies and paid or free media advertising.
2. Make worksites (e.g., conferences and meeting spaces) tobacco free and encourage those in leadership positions to support smoke free policies in their communities.
3. Promote and provide tobacco free environments (e.g., smoke free commercial or residential property).
4. Restrict the marketing and promotion of tobacco products to children and youth and implement and enforce policies and programs to reduce access to tobacco products.
5. Work with local policy makers to implement comprehensive tobacco prevention and control programs.

Recommendation 2: Expand use of tobacco cessation services.

1. Provide evidence-based incentives to increase tobacco cessation, consistent with existing law.
2. Implement evidence-based recommendations for tobacco use treatment and provide information to patients on the health effects of tobacco use and secondhand smoke exposure.
3. Implement provider reminder systems for tobacco use treatment (e.g., vital signs stamps, and electronic medical record clinical reminders).
4. Provide employees and their dependents with access to free or reduced-cost cessation supports and encourage utilization of these services.
5. Reduce or eliminate patient out-of-pocket costs for cessation therapies.

Recommendation 3: Use media to educate and encourage people to live tobacco free.

1. Implement sustained and effective media campaigns, including raising awareness of tobacco cessation resources.

The *Virginia Chronic Disease Prevention Shared Agenda* was coordinated through the Virginia Department of Health and supported through funding provided by the Collaborative Chronic Disease, Health Promotion and Surveillance Grant - Cooperative Agreement #3U58DP001995-03W2 from the Centers for Disease Control and Prevention.



Appendix A: Measures for Key Indicators

Active Living

Key Indicator	Data Source	Frequency	US Baseline (yr)	VA Baseline (yr)	Reporting (yr)
Proportion of adults who meet physical activity guidelines for aerobic physical activity.	National Health Interview Survey, Centers for Disease Control and Prevention, National Center for Health Statistics	Annually	47.2% sufficiently active met aerobic guidelines 20.7% met both muscle strengthening and aerobic guidelines <i>Summary Health Statistics for U.S. Adults: National Health Interview Survey 2008</i>	South (includes VA): 44.9% sufficiently active met aerobic guidelines 18.8% met both muscle strengthening and aerobic guidelines <i>Summary Health Statistics for U.S. Adults: National Health Interview Survey 2008</i>	
Proportion of adolescents who meet physical activity guidelines for aerobic physical activity.	Youth Risk Behavior Surveillance System, Centers for Disease Control & Prevention, National Center for Chronic Disease Prevention & Health Promotion	Biennially	25.8% Percentage of high school students who were physically active at least 60 minutes/day on all 7 days <i>Youth Risk Behavior Survey, 2011</i>	24.1% Percentage of high school students who were physically active at least 60 minutes/day on all 7 days <i>Youth Risk Behavior Survey, 2011</i>	
Proportion of Virginia's public and private schools that provide access to their physical activity spaces and facilities for all persons outside of normal school hours.	National Prevention Strategy, National Prevention Council	Periodically	28.8% <i>National Prevention Strategy 2011</i>	No state data available	

Healthy Eating

Key Indicator	Data Source	Frequency	US Baseline (yr)	VA Baseline (yr)	Reporting (yr)
Proportion of adults and children and adolescents who are obese.	Childhood Obesity Action Network. State Obesity Profiles, 2009. National Initiative for Children's Healthcare Quality, Child Policy Research Center, and Child and Adolescent Health Measurement Initiative.	Annually, released in 2-yr increments biennially	Adults 35.7% <i>BRFSS 2011</i> Children (6-11) 14% Adolescents (12-19) 17.1%	Adults 29.2% <i>BRFSS 2011</i> Children and Adolescents 31%	
Average daily sodium consumption in the population.	National Health and Nutrition Examination Survey, Centers for Disease Control and Prevention, National Center for Health Statistics, US Department of Agriculture, Agricultural Research Service	Annually, released in 2-yr increments biennially	Estimated percent of adults aged 20-39 years, without hypertension, and non-black, who met recommended sodium intake levels of less than 2,300 mg/day: 18.8% <i>NHANES, 2006</i>	No state data available	
Proportion of infants who breastfed exclusively through 6 months.	National Immunization Survey, Centers for Disease Control and Prevention, National Center for Immunization and Respiratory Diseases, National Center for Health Statistics	Annually	16.3% <i>National Immunization Survey 2009</i>	7.0% <i>National Immunization Survey 2007</i>	

Clinical and Community Preventive Services

Key Indicator	Data Source	Frequency	US Baseline (yr)	VA Baseline (yr)	Reporting (yr)
Proportion of adults aged 18 years and older with hypertension whose blood pressure is under control.	National Health and Nutrition Examination Survey, Centers for Disease Control and Prevention, National Center for Health Statistics	Annually, released in 2-yr increment biennially	Prevalence of hypertension (systolic ≥ 140 mmHg or diastolic ≥ 90 mmHg or reported use of antihypertensive medication) for adults 18 years and over: Total 29%, males 30%, females 28% <i>NHANES 2005-2006</i>	No state data available	
Proportion of adults aged 20 years and older with high-low-density lipoprotein (LDL) cholesterol whose LDL is at or below recommended levels.	National Health and Nutrition Examination Survey, Centers for Disease Control and Prevention, National Center for Health Statistics	Annually, released in 2-yr increments biennially	Percent of adults (age-adjusted) with high serum total cholesterol (≥ 240 mg/dl): Total 13.4%, Men 12.2%, Women 14.3% <i>NHANES 2009-2010</i>	No state data available	
Proportion of adults aged 50 to 75 years who receive colorectal cancer screening based on the most recent guidelines.	Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention	Periodically	65.4% <i>BRFSS data 2010</i>	63.6-68.9% <i>BRFSS data 2010</i>	
Proportion of persons (from racial/ethnic minority groups) in fair or poor health	National Health Interview Survey, Centers for Disease Control and Prevention, National Center for Health Statistics	Annually	Black 19.7% American Indian/ Alaskan Native 19.7% Asian 10.4% Pacific Islander 27.1% Two or More Races 18.4% Hispanic/Latino 16.6%	South: 14.4% total population; cannot be sorted by race or ethnicity <i>Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2010</i>	

Tobacco Free Living

Key Indicator	Data Source	Frequency	US Baseline (yr)	VA Baseline (yr)	Reporting (yr)
Proportion of adults who are current smokers (have smoked at least 100 cigarettes during their lifetime and report smoking every day or some days).	National Health Interview Survey, Centers for Disease Control and Prevention, National Center for Health Statistics	Annually	19.3%	South: 20.9% <i>Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2010</i>	
Proportion of adolescents who smoked cigarettes in the past 30 days.	Youth Risk Behavior Surveillance System, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion	Biennially	7.8% Percentage of high school students who currently smoked cigarettes <i>YRBS, 2011</i>	10.7% Percentage of high school students who currently smoked cigarettes <i>YRBS, 2011</i>	
Proportion of youth aged 3 to 11 years exposed to secondhand smoke.	National Health and Nutrition Examination Survey, Centers for Disease Control and Prevention, National Center for Health Statistics	Annually, released in 2-yr increments biennially	During 2007-2008, 18.2% of children aged 3-11 years lived with someone who smoked inside the home, compared with 5.4% of adults aged ≥20 years. <i>CDC, Vital Signs: current cigarette smoking among adults aged ≥18 years-United States, 2009. MMWR 2010; 59(35)</i>	2009, 48% of middle school and high school students reported being exposed to secondhand smoke in indoor places in the last seven days, and 37% lived with someone who currently smokes. <i>Virginia Foundation for Healthy Youth, Virginia Youth Tobacco Survey, 2008</i>	